NeuroScience Associates

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Check button if you currently have any of the following problems:

CONSTITUTIONAL

- Chills
- Fatigue
- Fever
- Weight loss/Weight gain
- Other:

CARDIOVASCULAR

- Chest Pain
- High Blood Pressure
- Edema
- Palpitations
- Other:

REPRODUCTIVE

- Vaginal discharge
- Irregular menses
- Erectile dysfunction
- Penile discharge
- Other:

PSYCHIATRIC

- Anxiety
- Depression
- Insomnia
- Paranoia
- Other:

HEENT

- Dental Problems
- Hearing Loss
- Nasal drainage/Sinus
- Blurred/Double vision
- Glaucoma
- Other:

GASTROINTESTIONAL

- Incontinence
- Change in stool
- Constipation
- Nausea
- Vomiting
- Other:

INTEGUMENTARY

- Redness
- Rash
- Hives
- Skin lesion
- Hair loss
- Other:

METABOLIC/ENDO

- Nipple Discharge
- Heat/Cold intolerance
- Diabetes
- Excessive Thirst
- Excessive Hunger
- Other:

RESPIRATORY

- Chronic cough
- Shortness of Breath
- Wheezing
- Asthma
- Other:

GENITOURINARY

- Urinary frequency
- Urinary incontinence
- Urinary retention
- Painful Urination
- Other:

NEUROLOGICAL

- Dizziness
- Numbness
- Weakness
- Tingling
- Gait disturbance
- Headache
- Memory loss/confusion
- Tremor
- Seizures
- Other:

MUSCULOSKELETAL

- Back pain
- Neck pain
- Joint pain
- Joint swelling
- Muscle weakness
- Other:

HEMATOLOGIC/LYMPH

- Easy bleeding
- Easy bruising
- Other:

IMMUNOLOGIC

- Seasonal allergies
- Food allergies
- Other:

The above information is accurate to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date